STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005022	A. BUILDING: _____ B. WING _____	C 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOSPITAL INC	1606 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State hospital complaint investigation. Complaint Number: IN00202277 Unsubstantiated: lack of sufficient evidence. Survey Date: July 13, 2016 Facility Number: 005022 Union Hospital is in compliance with 410 IAC 15-1.5-10 Utilization Review and Discharge Planning. QA: 7/19/16 jlh	S 000		